STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085031	A. BUILDING _____ B. WING _____	06/10/2011

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SHIPLEY MANOR	2723 SHIPLEY ROAD WILMINGTON, DE 19810

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from June 3, 2011 through June 10, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 66. The survey Stage II sample totaled twenty-eight (28) residents.	F 000	This plan of correction is prepared and executed because it is required by the provisions of the state and not because Shipley Manor agrees with the allegation and citation(s) listed on the statement of deficiencies. Shipley Manor maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall serve as Shipley Manor's credible allegation of compliance as of the last plan of correction completion date. By submitting this plan of correction, Shipley Manor does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Shipley Manor reserves all rights to raise all possible contentions and defense in any civil or criminal claim, action, or proceeding.	
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that notice was provided to residents before a room change or when receiving a new roommate for 2 residents (R66 and R107) out of 28 Stage 2 sampled residents. Findings include: Review of the facility's procedure, "Roommate Change" indicated that social services would notify residents according to state regulation whenever they are to receive a new roommate. Whenever possible the notice should be provided 24 hours in advance of the change. Documentation of the roommate change may be through an interim progress note.....or the roommate change notification form. Cross refer F205	F 247		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kendyl S. Nerad — TITLE: Executive Director — (X6) DATE: 7/11/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 247	Continued From page 1 1. R107 was transferred to the hospital on 12/30/10 and returned to the facility on 1/6/11. The facility failed to do a bed hold notification with this resident and upon return to the facility R107 was moved to another room. 2. R66 had three roommate changes during 12/2/10 through 3/11/11. R66 was not notified of a new roommate on 12/2/10, 12/10/10 and 3/11/11 prior to receiving a new roommate. Review of R66's social service notes lacked evidence that she had been notified regarding each of these roommate changes. The facility failed to ensure that R107 and R66 received notice before the resident's room or roommate was changed. During an interview on 6/8/11, E1 (Administrator) confirmed these findings.	F 247	**F247** 1. R66 and R107 have not received new roommates nor experienced a room change since this finding. Resident interviews conducted by Director of Social Services with both R66 and R107 resulted in finding both residents' verbalized satisfaction with current room and roommate. No negative outcome was identified. 2. All residents who experience a room change or a new roommate have the potential to be affected by the same practice. An audit of all resident room changes and new roommates will be conducted by the Director of Social Services or designee for the previous 60 days to ensure compliance with regulation and "Roommate Change" facility procedure for proper notification and documentation. Policy variances will be immediately corrected to achieve resident satisfaction with current room and roommate. 3. Education will be conducted with the Director of Social Services regarding "Roommate Change" facility procedure for proper notification and documentation. A monthly audit will be conducted by the Director of Social Services or designee of all resident room changes and roommate changes for "Roommate Change" facility procedure for notification and documentation compliance. Policy variances will be immediately corrected.	7/27/11
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279		

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F 279	Continued From page 2 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for one (R149) out of 28 residents sampled the facility failed to develop care plans for the identified needs of the residents. Findings include; Cross refer F314, example #2 R149 was admitted to the facility on 2/14/11 post hospitalization for a left thalamic intracerebral and intraventricular hemorrhage (bleed in the brain) with resultant right sided body weakness (hemiparesis) and expressive aphasia (person knows what he or she wants to say yet has difficulty communicating it to others). A Braden Scale (standardized tool used to assess risk for development of pressure ulcers) completed on 2/14/11 identified R149 as being at moderate risk (score of 14) for development of pressure ulcers. The facility's "Skin Risk Factors/Analysis and Interventions" form stated it was "to be used as a guide to identify risk factors and temporary care plan for interventions. Should be done in conjunction with the Braden on all residents." The interventions checked off included, "Position resident with pillows or support devices...Turn and reposition, Bed (every) 2 hrs...elevate heels off bed..." Although the facility developed a care plan for the	F 279	4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes. **F279** 1. R149 does not currently have a pressure ulcer and care plan was reviewed and revised on 6/9/2011 to include interventions to aid in the prevention of a pressure ulcer, including off-loading, skin prep, and a splint. 2. All residents who are admitted and/or readmitted to the facility and assessed, using the Braden Scale, with a moderate risk (or higher) or who currently have a pressure ulcer have the potential to be affected by the same practice. An audit of all new facility resident admissions and readmissions within the previous 60 days will be conducted by the DON or designee for Braden Scale assessment and care plan intervention initiation to aide in the prevention of pressure ulcers. Variances to the policy will be immediately corrected.	7/27/11 7/27/11

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F 279	Continued From page 3 potential for impaired skin integrity, they failed to include interventions to aid in the prevention of a pressure ulcer (e.g. skin prep, off loading) when on admission a weekly skin check noted a red area on the right heel.	F 279	3. Education will be conducted with all licensed nursing staff regarding Braden Scale assessment and pressure ulcer prevention care planning initiation using the "Skin Risk Factors/Analysis and Interventions" form.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, it was determined that the facility failed to review and revise the plan of care for one (R27) out of 28 Stage II sampled residents. Findings include:	F 280	A weekly audit will be conducted by the DON or designee for compliance of all residents' admission and/or readmission Braden Scale assessment and pressure ulcer prevention care planning. Variances to the policy will be corrected immediately. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

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F 280	Continued From page 4 R27 was admitted to the facility on 7/27/09. Review of the PASRR Level II determination letter dated 1/24/11, revealed that R27 had mental retardation, a developmental disability and cerebral palsy. The PASRR indicated that R27 required continued nursing facility residence and specialized services that included QMRP case management and day habilitation/rehab program (daycare at another facility daily). Review of R27's quarterly MDS (Minimum Data Set) assessment, dated 5/27/11, revealed that R27 had short and long term memory problems and was moderately impaired for skills of daily decision making. His daily activities listed on the MDS included reading books, spending time away from facility, snacks, staying up past 8 PM and doing things with a group of people. Observations of R27 during 6/3/11 to 6/8/11 revealed that the resident attended an adult day care each day. On 6/9/11 at 9 AM, R27 was observed being picked up for day care. On 6/9/11 at 2:30 PM, R27 was observed returning from day care. Review of R27's activity care plan did not include R27's daily attendance at the day care outside of the facility. An interview with E2 (DON) on 6/8/11 at 10:30 AM and E16 (Nurse) on 6/9/11 at 8:17 AM revealed that R27 attended day care at (name) daily; left in the morning and returned at approximately 3:00 PM or 3:30 PM. E2 stated that they did not document when the resident left from or returned to the facility. E16 stated that R27 attended other activities at the facility when he	F 280	**F280** 1. The activity care plan for R27 has been reviewed and revised on 6/10/2011 to include day care program participation and attendance. No negative outcomes were identified. 2. All residents who attend day care programs outside the facility have the potential to be affected by this same practice. An audit of all residents who attend day care programs outside the facility was conducted by the Director of Recreation to ensure activities care plans are accurate. No other variances were identified. 3. Education will be provided to the Director of Recreation regarding activity care planning for residents who attend day care programs outside of facility. A monthly audit of all activity care plans will be conducted by the Director of Recreation or designee for compliance with comprehensive care planning requirements for residents who participate and attend day care programs outside of the facility. Policy variances will be immediately corrected. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	Continued From page 5 returned from the day care in the afternoon. An interview with E17 (Activity Director) and E16 on 6/9/11 at 10:05 AM revealed that R27's care plan did not include the daily Day Care. E17 stated that she kept the day care information for R27 in her notes and asked the surveyor, "Should it (day care attendance) be in the care plan?" The care plan failed to address the day care program R27 attended daily.	F 280	**F309** 1. Physician orders for R22's Geri Sleeves are followed timely and accurately with proper notation in medical records for periods when resident refuses. 2. All residents who have physician ordered Geri Sleeves have the potential to be affected by the same practice. An audit of all residents by DON or designee for compliance and documentation of physician ordered Geri Sleeves. No new policy variances were identified. 3. Education will be provided for all licensed nursing staff regarding physician ordered Geri Sleeves and documentation compliance for resident refusal of Geri Sleeves. A weekly audit will be conducted by the DON or designee of all residents' physician ordered Geri Sleeves for application and documentation accuracy and compliance. Variances to the policy will be corrected immediately. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one resident (R22) out of 28 sampled residents. The facility failed to ensure that Geri Sleeves were on R22's bilateral upper extremities according to the physician's order. Findings include: Cross refer F514	F 309		

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F 309	Continued From page 6 Record review revealed that R22 had a physician's order, dated 5/2/11, that stated "Geri Sleeves to bilateral upper extremities on at all times. May remove for ADL's (activities of daily living)". Observations from 6/6 through 6/10/11 revealed that R22 was not wearing the Geri Sleeves on the 7-3 shift. Interviews on 6/9/11 and 6/10/11with E13 (nurse) & E14 (nurse) confirmed that R22 was not wearing the Geri Sleeves as per the physicians order. During an interview with R22 on 6/8/11, he stated that he bumps his arms all the time and these areas of discoloration on his arms do not hurt. A Delaware Hospice admission note, dated 3/12/11stated "color good with multiple bruises on bilateral arms". Facility staff failed to provide the necessary care and services to R22 by not applying Geri sleeves to the arms of this resident who had a physician's order to have the sleeves on at all times except for ADL's.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	**F314** 1. R22's wound is now properly staged and care planned with appropriate treatment initiated according to facility policy. The appropriate corresponding treatment was implemented and the pressure sore has decreased in size and no infection is noted. R149's pressure sores were resolved on 6/6/11. The C.N.A. documentation now accurately reflects care and services provided according to the resident's care plan, including having both heels off loaded in bed with pillow rolls. R149's MDS is coded accurately for the prevalence of pressure ulcers. E7 (nurse) received re-education regarding the Data Collection Tool and the Weekly Skin Check assessment. E8 (nurse) received re-education regarding pressure sore staging and the Initial Wound Evaluation.	7/27/11

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F 314	Continued From page 7 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview it was determined that the facility failed to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for two (R22 and R149) out of 28 sampled residents. Findings include: Cross refer F441, #3. 1. Review of hospital records revealed that R22 had a physician's order, dated 3/8/11, to offload the lateral malleolus (ankle) and keep off pillow every shift. Hospital progress notes, dated 3/8/11, 3/9/11 and 3/10/11 stated that R22 had a wound to his right lateral ankle. On 3/12/11 R22 was re-admitted to facility from the hospital. The Data Collection Tool that was completed by E7(nurse) stated there were no wounds present. The weekly skin check assessment, completed on 3/12/11 by E7 (nurse) also lacked documentation of any right ankle wounds. On 3/16/11 a nurses note and Initial Wound Evaluation Form written by E8 (nurse) stated, - "Necrotic wound noted to right ankle measuring	F 314	2. All residents who have the potential to develop pressure sores or who presently have pressure sores have the potential to be affected by the same practice. An audit by the Director of Nursing or designee of all residents' comprehensive assessment and subsequent documentation (Data Collection Tool, Weekly Skin Check, C.N.A. Flowsheet, Initial Wound Evaluation Tool, and MDS) for the potential for pressure sores and/or who currently have pressure sores will be conducted to ensure assessment accuracy for staging and treatment to promote healing, prevent infection, and prevent new sores from developing. Immediate corrective action will be taken for policy variances identified.	7/27/11

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F 314	Continued From page 8 1.7x1.0. Wound Care Nurse notified. New order apply skin prep and dressing hydrogel every 3 days and off load heels and ankle while in bed." On 3/21/11, a Weekly Wound Progress Note from E4 (Wound Care Nurse) stated, "Right ankle intact deep purple area- no drainage, odor or complaint of pain." A 3/21/11 Physician's Order stated, " Discontinue transorbant Hydrogell dressing to right lateral ankle wound. Cleanse right ankle wound with normal saline, pat dry and apply Bactroban/Polysporin 1:1 mix and cover with clean dry dressing." During an interview with E4 (Wound Care Nurse) on 6/9/11 she confirmed that the assessments completed on 3/12/11 for the Data Collection Tool and the weekly skin assessment were inaccurate. E4 additionally confirmed that the 3/16/11 nurse note and Initial Wound Evaluation which stated the right ankle was necrotic were inaccurate. Due to the inaccuracies of the staging of the wound the facility failed to implement the appropriate corresponding treatment as stated in the facility policy. 2. R149 was admitted to the facility on 2/14/11 post hospitalization for a left thalamic intracerebral and intraventricular hemorrhage (bleed in the brain) with resultant right sided body weakness (hemiparesis) and expressive aphasia (person knows what he or she wants to say yet has difficulty communicating it to others). A Braden Scale (standardized tool used to	F 314	(F314 continued) 3. Education will be conducted for all licensed and certified staff regarding resident assessment, treatment, and documentation (Data Collection Tool, Weekly Skin Check, C.N.A. documentation, Initial Wound Evaluation, and MDS coding) for pressure sore prevention and treatment to prevent infection and promote healing which includes documentation according to regulation and facility policy. An audit will be conducted weekly by the DON or designee on all residents' comprehensive assessment and subsequent documentation for pressure sore prevention and treatment which promotes healing, prevents infection, and prevents new sore from developing, according to facility policy. Immediate corrective action will be taken on any variance. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

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F 314	Continued From page 9 assess risk for development of pressure ulcers) completed on 2/14/11 identified R149 as being at moderate risk (score of 14) for development of pressure ulcers. The facility's "Skin Risk Factors/Analysis and Interventions" form stated it was "to be used as a guide to identify risk factors and temporary care plan for interventions. Should be done in conjunction with the Braden on all residents." The interventions checked off included, "Position resident with pillows or support devices...Turn and reposition, Bed (every) 2 hrs...elevate heels off bed..." The facility's "Data Collection Tool" (completed by nurse on every admission), dated 2/14/11 stated that R149 had no wounds and that the right lower extremity is slightly contracted (abnormal shortening of muscle tissue, rendering the muscle highly resistant to passive stretching). The corresponding nurse's admission note, dated 2/14/11 and timed 3:00 PM stated, "...Skin is warm dry and intact (see skin assessment sheet)..." Review of the "Weekly Skin Check" sheet dated 2/14/11 noted a circled area on the body diagram of the R149's right heel with the notation "red." There was no other description or data found regarding this "red" heel noted on 2/14/11. On 2/14/11 the facility developed a care plan for the problem "potential for alteration in skin integrity related to decreased mobility" which included the approaches "Weekly skin checks; Encourage to turn and reposition each round; 2 people to pull up in bed to prevent shearing prn (as needed)." This care plan failed to include the interventions identified on the "Skin Risk Factors/Analysis and Interventions" form such as	F 314		

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F 314	Continued From page 10 "Position resident with pillows or support devices...Turn and reposition, Bed (every) 2 hrs...elevate heels off bed..." On 2/15/11 a Physical Therapy (PT) evaluation stated that R149 currently required "maximum assist" for bed mobility and had no active movement of the right lower extremity. Review of PT Treatment Flow Sheets revealed that on the week ending 3/2/11, R149 continued to require maximum assist with bed mobility and on the week ending 3/9/11, she progressed to being "moderate/maximum" assist. An admission Minimum Data Set (MDS) assessment, dated 2/21/11 stated R149's cognitive skills for daily decision making were moderately impaired, that there were short and long term memory problems and that R149 required extensive assistance of 2 persons for bed mobility. This same MDS stated the resident was at risk of developing pressure ulcers and did not currently have any unhealed pressure ulcers. Review of nurse's notes and treatment administration records from 2/14/11 through 3/7/11 lacked evidence that R149's heels were off loaded in an attempt to prevent the development of pressure ulcers. Review of computerized CNA data sheets from 2/15/11 through 3/7/11 revealed that for 34 of 63 shifts for "was Resident turned and repositioned according to care Plan" that "Activity Not Required," was entered by the CNAs, indicating that R149 was not turned and repositioned on those shifts. Review of the clinical record revealed that in	F 314		

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F 314	Continued From page 11	F 314		

addition to the initial skin check on admission (2/14/11), Weekly Skin Checks were completed on 2/16/11, 2/23/11 and 3/2/11. There were no identified areas of concern for pressure ulcers noted. On 3/6/11, the Weekly Skin Check stated "(Right) ankle red with small white center Left + Right heels are boggy." The corresponding nurse's note, dated 3/6/11 and timed 10:30 AM stated "...Noted small red area (with) white center on outer aspect of Right ankle. Heels are boggy..."

On 3/7/11 an "Initial Wound Evaluation" was completed by E4 (Wound Care Nurse-WCN). This evaluation identified three wounds on R149's right lower extremity as follows:
Wound #1: Right lateral ankle Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) measuring 0.6 cm length x 0.6 cm width x 0.1 cm depth with a beefy red wound bed;
Wound #2: Right lateral foot Stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence) measuring 1.6 cm length x 1.7 cm width x 0 cm depth;
Wound #3: Right lateral heel blanchable redness only (not classified as a pressure ulcer).

Physician's orders were written on 3/7/11 for treatments for the wounds, as well as orders for skin prep every shift to both heels and to offload both heels in bed with pillow rolls. Review of weekly wound progress notes revealed that although Wound #2 progressed to a Stage II, all the wounds had resolved by 6/6/11. Review of the 6/11 monthly physician's order sheet revealed

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F 314	Continued From page 12 that R149 continued to have an order to off load both heels in bed with pillow rolls. R149 was observed on 6/8/11at 1:40 PM lying in bed on her back. R149's left leg was extended in bed with the heel in direct contact with the mattress. R149's right leg was bent at the knee with the outer ankle and heel in direct contact with the mattress. The facility failed to off load both heels as per physician's orders. During an interview with E19 (CNA) on 6/10/11 at 10:50 AM, E19 stated that R149 required more help turning and repositioning in bed when first admitted than she needed now after having had therapy. E19 stated that when she placed the resident in bed she off loaded both heels, but that she could not speak for any other staff. E19 confirmed that the CNAs do not document off loading of heels. On 6/10/11 at 11:20 AM during an interview with E1 (Administrator), E2 (DON) and E3 (ADON) they acknowledged that the facility failed to include preventative interventions, such as skin prep and off loading, prior to the development of R149's pressure ulcers. They also acknowledged that the facility's documentation did not support that turning and repositioning was consistently completed according to the plan of care.	F 314	**F323** 1. The laundry room door lock was replaced on 6/10/11. There were no residents affected by the practice. 2. All residents have the potential to be affected by the same practice. An audit was conducted by the Director of Environmental Services of all facility rooms/closets that have chemicals in store for properly locking mechanisms to keep chemicals inaccessible and found all other locks working properly. No new variances to policy were identified. 3. Education will be provided to all Housekeeping, Laundry, and Maintenance staff who routinely access locked chemical storage areas regarding safe chemical storage room security through properly working locking mechanisms (door lock or key pad). An audit will be conducted weekly by the Director of Environmental Services or designee of all chemical storage areas to ensure that locks are operating properly to keep chemical inaccessible and maintain a safe environment. Policy variances will be corrected immediately.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain the environment free from accident hazards as evidenced by accessible chemicals in an unlocked laundry room. Findings include: An observation of the laundry washer room on 6/9/11 at 10:15 AM revealed the door was unlocked and hazardous chemicals were accessible to residents and visitors. The door knob was observed with a lock and the door had a coded key pad that was in disrepair. During an interview on 6/9/11, E12 (Laundry staff) revealed that the door has a lock yet, staff did not get a key so the door had remained unlocked. E12 stated that the coded key pad did not work and confirmed that the door to the washer room where chemicals were stored was kept open all the time. An interview with E9 (Housekeeping/Laundry Director) on 6/9/11 also confirmed this finding.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325	**F325** 1. R173's fluid intake was immediately coordinated and tracked using "CareTracker" (electronic documentation system) which accounts for all fluid intake and resident compliance with therapeutic diet according to physician's order. No negative outcome was identified and R173's fluid intake has been consistent with the fluid restrictions of the therapeutic diet and less than 1200cc/day. 2. All residents who are on a therapeutic diet that requires the coordination, collection, and tracking of fluid intake have the potential to be affected by the same practice. The Director of Nursing conducted an audit of all residents' therapeutic diets and one other resident was identified with the need for fluid intake monitoring and tracking. Corrective action was immediately implemented to ensure compliance with fluid restriction parameters.	7/27/11

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F 325	Continued From page 14 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that there was a consistent system to track all components of the therapeutic diet for 1 (R173) out of 28 Stage 2 Sampled residents. The physician's order for R173's renal carbohydrate controlled diet included a fluid restriction of 1,200 cc/day. The facility failed to have a coordinated system to monitor the fluid intake for R173. Findings include: R173 was admitted to the facility on 6/1/11 with diagnoses of end stage renal disease with dialysis services, congestive heart failure, hypertension, diabetes and peripheral arterial and venous disease (conditions of the blood vessels that leads to narrowing and hardening of the arteries that supply the legs and feet). R173's physician ordered a renal, carbohydrate controlled diet with a fluid restriction of 1,200 cc/day. On 6/5/11, R173's physician ordered 1 can of Nepro (nutritional supplement used for individual on dialysis) per day at the resident's request. Review of an initial Nutrition Care Plan, dated 6/8/11, revealed that R173 had a plan of	F 325	3. Education will be provided to all licensed nursing staff and designated Dietary staff regarding the coordination, collection, and tracking of therapeutic diets that involve fluid restrictions utilizing CareTracker. An audit will be conducted weekly by the Director of Nursing or designee to ensure that all therapeutic diets that have fluid restrictions utilize CareTracker and complies with the coordination, collection, and tracking of fluid according to physician's orders. Variances to the policy will be corrected immediately. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

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F 325	Continued From page 15 action/approaches that included: "Diet as ordered - CCHO (carbohydrate controlled), Renal with 1200 cc FR (fluid restriction); ...Provide supplements as ordered". On 6/8/11 at 8:45 AM, R173 was observed as she had just finished breakfast and her breakfast tray with the diet slip were present. The diet slip noted, "Renal, CCHO, NSP (nonstarch polysaccharides/dietary fiber), 1200 cc Fluid R (restriction)". The diet slip had, "only 8 oz (ounces) fluids on tray" but then incorrectly listed more than 8 ounces, "Coffee - 1 cup (8 oz); 2% milk - 8 oz and creamer - 1 ea (each)". R173 stated that she had 4 oz of coffee and 4 oz of milk on 6/8/11 for breakfast. On 6/8/11 9:30 AM, in an interview, E18 (Assistant Director of Food and Beverage) reviewed the diet slip. E18 confirmed the discrepancy on the diet slip regarding the amount of fluids and that she would check in the computer to change the diet slip to reflect a total of 8 ounces per meal on it. Additionally, E18 stated that what was on the diet slip should match what is on the tray. R173's 6/11 Meal and Fluid Detail report for dietary intake of fluids was reviewed. Additionally, the 6/11 Medication Administration Record (MAR) where nursing staff recorded the fluids provided during the administration of medications to R173 as well as the supplement, Nepro (1 can/240 cc daily) was reviewed to assess the daily fluid consumption of R173. Review of the 6/11 MAR revealed from 6/1 to 6/3/11, "Fluid Restriction 1200 cc, 800 cc	F 325		

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F 325	Continued From page 16 Dietary/400 cc Nsg (nursing)" which was then crossed out and "See clarification" was written. On 6/3/11, the 6/11 MAR had, "1200 cc Fluid Restriction: Dietary = 720 cc TV (total volume), Nsg = 160 cc TV". The MAR then had 11 PM - 7 AM, 7 AM - 3 PM and 3 PM - 11 PM shifts noted with the amount of cc's per shift. The total volume of the nursing fluid restriction was incorrectly written on the MAR as 160 cc TV which was actually the fluids per shift rather than 480 cc TV per day. There were blanks on the MAR for the fluid restriction on 6/3 and 6/4 for the 3 PM - 11 PM shift and on 6/6 for the 11 PM - 7 AM shift. Additionally, the 6/11 MAR had Nepro with medication pass (TV 240 cc) of 80 cc per shift which was started on 6/6/11 on another sheet of the MAR. On 6/8/11, R173's 6/11 Meal and Fluid Detail report for dietary intake of fluids and the 6/11 MAR for fluids provided by nursing staff was reviewed by E3 (ADON) in the surveyor's presence. On 6/8/11, in an interview with E3, she stated that she did not know if the Nepro was being signed off in one section of the 6/11 MAR and whether or not it was being included in the nursing fluids per shift under fluid restriction. E3 asked E20 (RN) if she included Nepro under the nursing fluids provided to R173 per shift? E20 stated that she considered Nepro separate from the other fluids and signed the 80 cc of Nepro and then signed for the other fluids under the fluid restriction per shift. Additionally, E3 stated that the fluid restriction was confusing since the total volume for nursing incorrectly had 160 cc's which was the fluids that nursing provided per shift not per day. E3 stated that it was difficult to track the fluid restriction as it was set up. E3 stated that	F 325		

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F 325	Continued From page 17 she would work with staff to ensure that the fluid restriction was maintained. The 1200 cc fluid restriction per day was not maintained for R173 on the following days: Date Dietary Nursing Nepro Total fluids/day 6/2/11 880 cc 600 cc - 1,480 cc/day 6/3/11 960 cc 320 cc - 1,280 cc/day 6/5/11 1080 cc 150 cc - 1,230 cc/day 6/6/11 1020cc 300 cc 240 cc 1,560 cc/day 6/7/11 840 cc 260 cc 240 cc 1,340 cc/day. The facility failed to maintain the fluid restriction of 1200 cc's as part of R173's therapeutic diet. On 6/9/11 in an interview with E2 (DON), she stated that she spoke with E3 who informed her of the confusion regarding the facility's system to track R173's fluid restriction. E2 confirmed the findings that the fluid restriction for the resident was not consistently followed.	F 325	**F329** 1. R56 had laboratory work completed on 6/9/2011 with findings within normal limits. 2. All residents that have a physician's order for Furosemide/diuretic (water pill) have the potential to be affected by the same practice. An audit was conducted by the Director of Nursing of all residents who have a physician's order for Furosemide/diuretic to ensure that laboratory services recommended to monitor electrolyte levels were ordered by the physician, drawn by the laboratory, and values reported to the physician. No new policy variances were identified. 3. Education will be provided to all licensed nursing staff regarding clinical indicators for laboratory services with the use of Furosemide/diuretics. An audit will be conducted monthly by the Director of Nursing or designee on all residents who have a physician's order for Furosemide/diuretics to ensure that laboratory services that are physician ordered are provided to monitor electrolyte levels. Variances to the policy will be corrected immediately. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	Continued From page 18 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R56) out of 28 sampled residents was free from unnecessary drugs. The facility failed to monitor laboratory values for R56 who was receiving Furosemide. Findings include: Review of R56's drug regimen revealed she had been receiving Furosemide (water pill) since 2/6/2008. The clinical record lacked evidence that blood work to monitor for electrolyte abnormalities had been drawn at anytime during the past 19 months. During an interview with E3 (ADON) on 6/8/11 at 2:00 PM, E3 acknowledged the lack of monitoring of laboratory values during use of the Furosemide.	F 329		
F 372 SS=B	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372		

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F 372	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations of the dumpster area and staff interviews, it was determined that the facility failed to keep the dumpster free of debris to prevent pest harborage. Additionally, a trash can inside the kitchen remained open, uncovered. The lid to this trash can was designed with an opening to maintain refuse covered but stayed in the open position when put on the can. Findings include: 1. Observations of the dumpster area on 6/3/11 at 8:30 AM revealed debris on the floor around the dumpster area such as soiled gloves, papers and plastics. An interview with E5 (Director of Food and Beverage) on 6/3/11 confirmed this finding. Additionally on 6/3/11, observations of the kitchen dishwasher area revealed a large garbage barrel with food refuse was uncovered. The domed lid with an opening in the lid was observed on the floor and not in use. An interview with E6 (kitchen staff) on 6/3/11 revealed that when the lid was placed on the food refuse barrel, it stayed open. This created potential for pest harborage. An interview with E5 on 6/3/11 confirmed this finding. 2. Observations of kitchen water drains on 6/3/11 revealed heavy food debris on the drain located under the Hobart convection oven. The drain was observed with grate not covering the hole on the floor. 3. Observation of the drain located under the	F 372	**F372** 1. The dumpster area was immediately power washed according to facility procedure with no remaining debris. The large garbage barrel had the domed lid replaced for proper food refuse coverage. All of the kitchen drains were cleaned and grates replaced to properly cover drain. 2. All exterior dumpster areas, internal trash barrels, and kitchen drains have the potential to be affected by this practice. The Director of Food and Beverage corrected these areas immediately and completes a Daily Rounds Audit to ensure continued compliance. No new policy variances were identified. 3. Education will be provided to all Food and Beverage staff regarding proper maintenance of dumpster area, garbage barrel lids, and kitchen drains to ensure compliance with regulation and facility standards for proper garbage and refuse handling. The Director of Food and Beverage or designee will complete the Daily Rounds Audit of the dumpster area, trash barrel lids, and kitchen drains to ensure that compliance is maintained. Variances will be corrected immediately. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

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F 372	Continued From page 20 refrigerated food table/counter on 6/3/11 revealed heavy food debris inside the drain on the floor. An interview with E6 on 6/3/11 confirmed this finding.	F 372		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the irregularities report by the licensed pharmacist during the monthly medication regime review (MRR) were reported to the attending physician and/or the director of nursing (DON) and acted upon for one (R56) out of 28 sampled residents. Findings include: Review of R56's 1/14/10 MRR documented that the consultant pharmacist had recommendations for nursing and the physician. A notation written in by the consultant pharmacist on the MRR stated, "P (physician) add BMP (Basic metabolic Panel) to Aug (August) labs-yearly." While the MRR was in the clinical record the clinical record lacked a copy of this recommendation and the facility was	F 428	**F428** 1. Original document of licensed consultant pharmacist recommendations was unable to be found, however, facility followed MRR recommendations and forwarded it to R56's attending physician and facility Director of Nursing for physician's determination for action which resulted in the attending physician's order for an annual BMP (Basic metabolic panel) on 6/9/2011 with laboratory results within normal limits for this resident. No negative outcome was identified. 2. All residents with recommendations from the licensed consultant pharmacist during the monthly medication review (MRR) have the potential to be affected by the same practice. An audit will be conducted by the licensed consultant pharmacist and Director of Nursing on the previous 2 (two) month's monthly medication review (MRR) recommendations to ensure that recommendations were reported to the attending physicians for action. Variances to the policy will be immediately corrected.	7/27/11

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F 428	Continued From page 21 unable to provide one. Although the facility contacted the consultant pharmacist, they also were unable to provide a copy of the recommendation report. Record review lacked evidence that the irregularity was reported to the DON or acted upon. Findings were reviewed with E1 (administrator), E2 (DON) and E3 (ADON) on 6/10/11.	F 428	3. Education will be provided to the Consultant Pharmacist, Director of Nursing, Assistant Director of Nursing and RN Supervisors regarding the monthly medication review (MRR) and facility policy for physician action to licensed consultant pharmacist recommendations. An audit will be conducted monthly by the Director of Nursing or designee of all monthly medication review (MRR) recommendations to ensure that recommendations are forwarded to the attending physician for review and action. Immediate corrective action will occur for identified variances. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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	085031	A. BUILDING _____ B. WING _____	06/10/2011

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F 441	Continued From page 22 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to maintain an infection control program under which it analyzed trends and investigated any increase in the rate of infection to prevent the development and transmission of disease and infections. The facility failed to wash hands and glove appropriately during a wound treatment for one (R22) out of 28 Stage II sampled residents. Additionally, the facility failed to handle, store, and process linens so as to prevent the spread of infection regarding nonworking vents and storage of soiled linen. Findings include: The facility's Infection Control Policy and Procedure was reviewed. 1. Review of the monthly Infection Control logs and mapping from October 2010 to April 2011 with E2 (DON, Infection Control Nurse) on 6/9/11 at 8:30 AM revealed that the facility monitored the occurrence of infections, however, it failed to trend the organisms to determine if there was a	F 441	**F441** 1. Facility trending of Infection Control data for organisms and trends for acquired versus non-facility acquired infections are incorporated into the QAA analysis for trends and investigate rates of infection to prevent the development and transmission of disease and infections. There are now trends or patterns identified for the previous three months. The "open window" between the soiled area and clean area of laundry was structurally removed on June 13, 2011 to eliminate the possibility of contaminated air exchange. The 500 unit soiled utility room exhaust was repaired on June 13, 2011 and is in proper working order. E4, Wound Care Nurse, received re-education on June 13, 2011 regarding proper clean dressing changes according to facility policy. No negative outcomes were identified.	7/27/11

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F 441	Continued From page 23 pattern of infection that the facility needed to address and then to implement corrective actions. The facility also failed to analyze infection data trends in relation to acquired infections versus non-facility acquired infections quarterly, investigate any increase in the rate of infections, and established controls to prevent infections in the facility. Interview with E2 on 6/9/11 confirmed this finding. E2 revealed that the infection line listings collected and the mapping were discussed at the QA (Quality Assurance) meetings yet confirmed she was not trending the data and that the reporting part did not exist. 2. The facility failed to handle, store, and process linens so as to prevent the spread of infection with regards to nonworking vents and storage of soiled linen. Observations of the laundry area with E9 (Housekeeping Director) on 6/9/11 revealed the soiled area of the laundry with an open window that connected to the dryer (or clean linen) area of the laundry. Contaminated air was being exchanged with the clean linen area. During an interview on 6/9/11, E9 confirmed this finding. Additionally on 6/9/11, observations of the 500 unit soiled utility room revealed that the exhaust vent was not working. During an interview on 6/9/11, E9, E10 (Maintenance staff) and E11 (Maintenance staff) confirmed this finding. 3. Review of the facility policy entitled, "Clean Dressing Change" and dated 06/01/07 stated, "Remove soiled dressing and gloves, place in bag	F 441	2. Infection Control trending and analysis, contaminated air exchange between clean and soiled linen areas, improper ventilation due to inoperable exhaust vent in soiled utility room, and improper dressing change have the potential to affect all residents. The Director of Nursing's Infection Control Report identifies no trends or patterns of infections and will be evaluated at least quarterly and presented at QAA. The Director of Environmental Services has audited all soiled utility areas to ensure no contamination exists and exhaust vents are working properly. No variances were identified. An audit of all licensed staff conducting clean dressing changes will be conducted by the Director of Nursing to ensure staff practice is in compliance with facility policy and regulation. Variances to the policy will be immediately corrected.	7/27/11

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F 441	Continued From page 24 for disposal. Wash hands and put on clean gloves." On 6/10/11 E4 (Wound Care Nurse) was observed performing a wound dressing change on R22's right ankle. E4 failed to wash her hands and change her gloves after taking off the old dressing. During an interview with E4 on 6/10/11, she confirmed that she did not follow facility policy for a clean dressing change because she did not wash her hands and change her gloves after taking off the old dressing and before applying the new treatment and dressing.	F 441	(F441 continued) 3. Education will be provided to all licensed nursing staff regarding facility policy for clean dressing changes. An audit will be conducted at the quarterly QAA meeting of the Infection Control Report which will include trending and analysis by organism and acquired versus non-facility acquired infections. An audit will be conducted weekly by the Director of Nursing or designee on 25% of staff conducting dressing changes to ensure compliance with policy. An audit will be conducted monthly by the Director of Environmental Services or designee of exhaust vents to ensure they are in proper working order in soiled utility areas and that cross-contamination of air between clean and soiled linen areas does not occur. Variances will be immediately corrected. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews it was determined that the facility failed to maintain clinical records for one (R22) out of	F 514		

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F 514	Continued From page 25 28 sampled residents in accordance with accepted professional standards and practices that are accurately documented. Findings include: Record review revealed that R22 had a physicians order, dated 5/2/11, that stated "Geri Sleeves to bilateral upper extremities on at all times. May remove for ADL's (activities of daily living)." Observations from 6/6/11 through 6/10/11 revealed that R22 was not wearing his Geri Sleeves on the 7-3 shift. Record review of the Treatment Administration Record (TAR) from 6/6/11 through 6/10/11 for the 7-3 shifts revealed that nursing staff documented that they applied R22's Geri Sleeves. Interviews on 6/9/11and 6/10/11 with E13 (nurse) and E14 (nurse) confirmed that R22 was not wearing the Geri Sleeves as per physicians order and that E13 and E14 initialed the TAR that they had applied the Geri Sleeves, when in fact they had not done so. The facility failed to maintain accurately documented clinical records for R22; records indicated that R22's Geri Sleeves were in place from 6/6/11 through 6/10/11 when they were not.	F 514	**F514** 1. R22's previous Treatment Administration Record (TAR) cannot be changed. R22's wears Geri Sleeves according to physician's order and documentation is correctly reflected in the Treatment Administration Record (TAR). 2. All residents with physician ordered Geri Sleeves have the potential to be affected by the same practice. An audit was conducted by the Director of Nursing of all Treatment Administration Records (TAR) to ensure that the treatment is accurately documented with regards to Geri Sleeve application. No other policy variances were identified. 3. All licensed nursing staff will receive education regarding Treatment Administration Record (TAR) documentation for physician ordered Geri Sleeve application. An audit will be conducted weekly by Director of Nursing or designee to ensure compliance with Treatment Administration Record (TAR) documentation accuracy and physician order compliance for the application of Geri Sleeves. Policy variances will be corrected immediately. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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F 520	Continued From page 26 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and interview, it was determined that the facility failed to have the Quality Assessment and Assurance (QAA) committee meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. Findings include: Review of the sign in sheets for the QAA meetings revealed that meetings were held 3/23/10, 8/17/10, 11/17/10 and 4/8/11. There was approximately a five month interval between the March and August meetings and the November	F 520	**F520** 1. No retroactive correction to missed QAA meeting(s) can be accomplished. No negative outcomes were identified. 2. No known residents were affected by the practice. 3. Education will be provided to the QAA Committee regarding regulatory and facility policy compliance. An audit will be conducted by the Executive Director/NHA or designee of quarterly meeting schedules of the QAA Committee (January, April, July, October) to ensure compliance with facility policy and regulation. Variances to the policy will be immediately corrected. 4. Audit findings will be reported to the NHA with immediate corrective action and the outcomes reviewed at the QAA meeting for compliance with audit frequency adjusted according to outcomes.	7/27/11

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F 520	Continued From page 27 and April meetings. The facility failed to have quarterly QAA meetings. On 6/7/11 in an interview, E1 (NHA) confirmed that the QAA committee meetings were not held quarterly as required.	F 520		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Shipley Manor

DATE SURVEY COMPLETED: June 10, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from June 3, 2011 through June 10, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 66. The survey Stage II sample totaled twenty-eight (28) residents.	Cross refer to CMS2567-L Survey report date completed 6/10/11, F205 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F247 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F279 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F280 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F309 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F314 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F323 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F325 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F329 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F372 7/27/11
3201 **3201.1.0** **3201.1.2**	**Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 6/10/11, F205, F247, F279, F280, F309, F314, F323, F325, F329, F372, F428, F441, F514 and F520.	

Provider's Signature Wendy M. Verrad Title Executive Director Date 7/11/11

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3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units for refuse and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.** **5-501.110 Storing Refuse, Recyclables, and Returnables.** **Refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.** **5-501.113 Covering Receptacles.** **Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered:** **(A) Inside the food establishment if the receptacles and units:** **(1) Contain food residue and are not in continuous use; or** **(2) After they are filled; and** **(B) With tight-fitting lids or doors if kept outside the food establishment.**	Cross refer to CMS2567-L Survey report date completed 6/10/11, F428 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F441 7/27/11 Cross refer to CMS256-L Survey report date completed 6/10/11, F514 7/27/11 Cross refer to CMS2567-L Survey report date completed 6/10/11, F520 7/27/11

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	This requirement is not met as evidenced by: Cross refer to the CMS 2567-L survey report date completed 6/10/11, F372.	